Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: THE SAN ANTONIO ORTHOPAEDIC SURGERY CENTER PO BOX 34533 SAN ANTONIO TX 78265	MFDR Tracking #: M4-05-2506-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERISURE MUTUAL INSURANCE CO Box #: 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The documentation provided demonstrated the quality of care was delivered to the patient. Cost control has been achieved through our application of a consistent, national recognized, regionally adjusted database of actual reimbursement for services rendered. Our fees were determined using the Ingenix database, which is a nationally accepted database." "This rate of reimbursement is acceptable to individuals for similar treatment of injured individuals of an equivalent standard of living in this region." "Our charges are fair and reasonable. Applying some other non-ASC calculation into the determination of fair and reasonable on your part is neither fair nor reasonable since there is no correlation to these non-ASC non-worked compensation calculations."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $1,493.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "See reconsideration, per Concentra, no additional payment is warranted, provider reimbursement is fair and reasonable."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/5/2004	Ambulatory Surgical Care (ASC) Services for CPT code 26776	Not Applicable	$1,493.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on November 22, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or

after January 1, 2003, the Division notified the requestor on December 8, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.800, effective July 15, 2000, requires ambulatory surgical centers to submit bills using the UB-92 billing form for institution services.

3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

4. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 8/20/2004

- M-No MAR
- (855-016)-Payment recommended at fair and reasonable rate $455.00.

Explanation of benefits dated 10/14/2004

- O-Denial after reconsideration.
- (920-002)-In response to provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.

Issues

1. What is the applicable rule for reimbursement?

2. Did the requestor support the position that additional reimbursement is due for ASC services for CPT code 26776? Is the requestor entitled to additional reimbursement?

Findings

1. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

2. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "The documentation provided demonstrated the quality of care was delivered to the patient. Cost control has been achieved through our application of a consistent, national recognized, regionally adjusted database of actual reimbursement for services rendered. Our fees were determined using the Ingenix database, which is a nationally accepted database." "This rate of reimbursement is acceptable to individuals for similar treatment of injured individuals of an equivalent standard of living in this region." "Our charges are fair and reasonable."
   - The requestor did not submit a copy of the Ingenix report to support their position.
   - The requestor submitted two redacted medical bills with check stubs to support their position that $1,948.00 is a fair and reasonable rate of reimbursement for ASC services for CPT code 26776. However, the requestor did not discuss or explain how the sample medical bills and check stubs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the medical bills and check stubs. Nor did the requestor explain or discuss the sample carrier(s) methodologies or how the payment amount was determined for each sample medical bill and check stub. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample medical bills and check stubs, was typical for the services in dispute.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of

payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the ASC services. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**June 16, 2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.